

California's Coordinated Care Initiative

Provider Presentation
February 2014



Roadmap

- About the Coordinated Care Initiative
- Value of Cal MediConnect for Providers
- Participating in Cal MediConnect
- Key Consumer Protections

Medicare and Medi-Cal Today

Medicare

Who: 65+, under 65 with certain disabilities

- Doctors
- Hospitals
- Prescription drugs

Medi-Cal

Who: low-income Californians

- Long-term services and supports
 - MSSP, IHSS, CBAS, nursing facilities, non-emergency medical transportation
- Durable medical equipment
- Medicare cost sharing

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Medicare and Medi-Cal are two different government programs to provide health care. Medicare is for seniors and those under 65 with certain disabilities, such as end-stage renal disease (ESRD). Medi-Cal is for low-income Californians. There are some Californians who qualify for BOTH programs, called Medi-Medi or dual eligible beneficiaries. They receive complementary services from each program. Medicare primarily covers medical services and prescription drugs, and Medi-Cal wraps additional services around that: help with transportation, vision, dental, cost sharing, long-term care, and durable medical equipment (DME). Medi-Cal also covers long-term services and supports including in-home supportive services (IHSS), community-based adult services (CBAS), the Multipurpose Senior Services Program (MSSP) and nursing home care.

Problems with the Current Delivery System

- Programs in silos
 - Who pays for what?
- Fundamentally: a lack of coordinated care
 - A lack of support for both providers and consumers



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The health care system is very fragmented for those “Medi-Medis” or “duals” who receive both Medicare and Medi-Cal. The programs pay for different but complementary services, but there is no incentive in the current system to help coordinate that care or share information between a beneficiary’s provider. This can be a critical issue as many of these beneficiaries are our most vulnerable.

The Necessity of Coordinated Care

- Some people with multiple chronic conditions see many different doctors and have multiple prescriptions.
- This is common among people with both Medicare and Medi-Cal (Medi-Medi or dual eligible beneficiaries) who are often sicker and poorer than other beneficiaries.
- Today's care delivery system doesn't always support the care coordination many people need. This leads to increased risk of admission to the hospital or nursing home.

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You know how much time your front office spends doing care management – reaching out to social services, mental health, Meals on Wheels, CBAS centers and other supports. Many dual eligibles have multiple and complex needs that go beyond the doctor's office – but they often struggle to navigate the fragmented system to get the services they need.

Person Centered Care

- Right Care
- Right Time
- Right Place



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The goal of Cal MediConnect is to bring Medicare and Medi-Cal services together in one health plan, and to support beneficiaries with care coordination to ensure that they receive the right care and the right support services at the right time in the right place.

The Coordinated Care Initiative: Where



*Participation in Orange County pending readiness reviews.

These changes, and this new program will be in 8 different counties

The Coordinated Care Initiative: Two Parts

Cal MediConnect

Who: many full dual eligible beneficiaries

- Optional
- Combines Medicare and Medi-Cal benefits into one managed care health plan
- Additional services, including care coordination

Medi-Cal

Managed Long-Term Services and Supports (MLTSS)

Who: Medi-Cal only beneficiaries, full dual eligibles who opt out of Cal MediConnect, other identified groups eligible for Medi-Cal

- Mandatory
- Beneficiaries will now receive Medi-Cal benefits through a managed care health plan, including LTSS and Medicare wrap-around.

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Many dual eligible beneficiaries in the eight counties will be eligible to enroll in a new program – Cal MediConnect. This program is optional, and beneficiaries will have a choice of plans that will combine their Medicare and Medi-Cal benefits and provide additional benefits and services, including care coordination.

Those who are not eligible for Cal MediConnect, or who opt out, will still have to choose a Medi-Cal managed care plan to receive their long-term services and supports. Their Medicare benefits will not change, whether they are in FFS or a Medicare Advantage plan.

<h2>Cal MediConnect</h2> <ul style="list-style-type: none">• Who: Medi-Medi beneficiaries• Optional	<ul style="list-style-type: none">• All of the Original Medicare and Medi-Cal services beneficiaries currently receive combined into one health plan• One number to call for all your needs• Additional vision and transportation benefit• Access to Interdisciplinary Care Team• Access to care manager• Coordinated care
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Cal MediConnect is a new program that will combine Medicare and Medi-Cal benefits into one managed care plan. This means that beneficiaries will have one number to call with questions – and providers will have one health plan to contact about an individual's varying needs from medical care to long term care. No more wondering if a service is Medi-Cal or Medicare.

Cal MediConnect plans will offer additional benefits to beneficiaries. They'll have access to supplemental vision and transportation benefits. And the plan will provide additional care coordination support.

There are people who are not eligible for Cal MediConnect.

- **Medi-Medi beneficiaries younger than 21.**
- **Medi-Medis with partial benefits or other health coverage.**
- **Home and Community Based Services waiver enrollees (except MSSP; all others must disenroll from those programs to be eligible for the Cal MediConnect; will not be passively enrolled).**
- **Medi-Medis with developmental**

<h2>Medi-Cal</h2> <p>Managed Long-Term Services and Supports</p>	<ul style="list-style-type: none"> • Same Medi-Cal services beneficiaries currently receive • Medi-Cal long-term services and supports (MLTSS) will now be provided through managed care plans • This impacts both beneficiaries not eligible for Cal MediConnect and beneficiaries who opt out of Cal MediConnect
<ul style="list-style-type: none"> • Who: Medi-Cal only beneficiaries, full dual eligibles who opt out of Cal MediConnect, other identified groups eligible for Medi-Cal • Mandatory 	

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Beneficiaries who are not eligible for Cal MediConnect or who choose to opt out will still need to enroll in a Medi-Cal managed care plan. Medi-Cal beneficiaries will receive some supplemental vision benefits. Their Medicare benefits will remain the same, whether they are delivered through Medicare FFS or Medicare Advantage.

<p>PACE Program of All-inclusive Care for the Elderly</p> <ul style="list-style-type: none">• Who: Medi-Medi beneficiaries and Medi-Cal beneficiaries• Option available to those who are determined eligible	<p>You may be eligible to enroll in a PACE program</p> <p>If you:</p> <ul style="list-style-type: none">• Are 55 or older• Live in your home or community setting safely• Need a high level of care for a disability or chronic condition• Live in a ZIP code served by a PACE health plan
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One option for those who do not want to go into Cal MediConnect is the PACE program. This is available only to some Medi-Medi beneficiaries. It is similar to Cal MediConnect in that it combines Medicare and Medi-Cal services to help provide care coordination to beneficiaries, but it has more restrictions than Cal MediConnect.

Value of Cal MediConnect

- Care Coordination
- Administrative Simplification

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Today's presentation will largely focus on Cal MediConnect, as it will entail larger changes for providers than MLTSS.

Care Coordination

- Cal MediConnect plans will give providers information and resources to support care coordination.
 - Health Risk Assessments (HRAs)
 - Interdisciplinary Care Teams
 - Individualized Care Plans
 - Plan Care Coordinators

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In Cal MediConnect, beneficiaries and their providers will have access to a number of care coordination tools.

Health Risk Assessments

- Cal MediConnect plans will conduct HRAs to identify higher risk beneficiaries who could benefit from care coordination.
 - These assessments will vary by plan, but all will include a core set of questions about a person's primary, acute, LTSS, and behavioral health and functional needs.
 - For your patients, the plan will automatically send you the results within 10 days of assessment completion.
 - HRAs will be complete within 45 – 90 days of enrollment, depending on a beneficiary's risk.

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In Cal MediConnect, beneficiaries and their providers will have access to a number of care coordination tools. First, health plans will conduct risk assessments of enrollees to identify higher or lower risk beneficiaries and determine who might benefit from more care coordination services. The results of this assessment will be available to give providers a more comprehensive understanding of the beneficiary's needs and providers can request a reassessment.

Interdisciplinary Care Teams

- Higher risk beneficiaries will be provided with a care team to help manage and coordinate their care.
 - Teams will be comprised of the beneficiary, the plan care coordinator and key providers.
 - The Cal MediConnect plan will ask you to participate in teams for your patients. You can ask to be included in a care team.
 - Your participation is valuable – you know your patients and what they need best.

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Higher risk enrollees will be asked if they would like to form an interdisciplinary care team, which will include their primary care provider, the health plan care coordinator and other providers at the enrollee's discretion. Enrollees with very difficult cases will have care teams even if they don't want them to provide support to their providers. Enrollees have the right to request a care team. ICTs will help providers get the information they need to care for beneficiaries.

Interdisciplinary Care Teams

- As a member of the team, you will automatically receive information from the patient's health risk assessment.
 - You also will be notified of a change in a patient's health status, care plans, discharge plans, hospital admission, and nursing facility placements.
- Care teams will be coordinated by the plan, providing support rather than adding to a provider's care and administrative burdens.

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Every plan will structure how they work with providers differently. How this will happen will be included in your contract with the plan.

Individualized Care Plans

- The care teams will develop and implement individualized care plans for beneficiaries.
- Care plans will facilitate timely access to primary care, specialty care, DME, medications, and other medical and long-term services and supports needed by the beneficiary.
- Care plans can identify services not traditionally covered by Medi-Cal or Medicare that can help support beneficiaries.

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Together, the ICT will develop an individualized care plan for beneficiaries that will outline all the different types of care and services they need, facilitating transitions between types of care as well as referrals for services. This plan can include care plan option services – services that are beyond existing Medi-Cal services but that will help beneficiaries stay in their homes and communities.

Plan Care Coordinator

- The plan care coordinator helps facilitate communication among the beneficiary's continuum of providers, including:
 - Medical
 - LTSS
 - Behavioral Health
- Communication processes will be developed jointly between the plan and providers.

Care Coordination: Example

Patient X recently had a stroke and is back living at home.

Before Cal MediConnect, the patient would have to navigate Medicare, Medi-Cal and county agencies to get needed social services – often relying on their doctor's office staff for help.

Under Cal MediConnect, a plan care coordinator will ensure the patient has:

- Transportation to appointments
- Coverage for prescriptions
- Meals on Wheels
- Other support for activities of daily living

Administrative Simplification

- **Under Cal MediConnect**, you will have one point of contact – the health plan – for all benefit questions and claims.
- **Under MLTSS**, Medicare services will still need to be billed to Medicare, Medi-Cal services will need to be billed to the MLTSS managed care plan. And services covered by both programs will be billed with Medicare as primary and Medi-Cal as secondary payer.

Participating in Cal MediConnect

- How Providers Will be Paid
- Contracting with Plans
- Continuity of Care

How will I get paid if my patients join Cal MediConnect?

- Health plans must have providers for all covered benefits and adequate access to all services – and are checked for this on an ongoing basis.
- You must join the health plans' networks to receive payment.
 - This means undergoing provider credentialing process and signing contracts.
 - For physician services, many health plans work through medical groups.

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Providers will have to contract with Cal MediConnect plans to participate.

How will I get paid if my patients are in FFS Medicare and MLTSS?

- The Medi-Cal managed care plan is responsible for adjudicating the Medi-Cal portion of services and responsible to pay in the same manner that Medi-Cal fee-for-service has paid in the past.
- Medicare will remain the primary payer and the Medi-Cal managed care plan is the secondary payer.

How will I get paid as an LTSS provider?

How – and whether – the CCI will impact how LTSS providers are paid depends on the type of service:

- **IHSS:** Nothing changes.
- **CBAS:** Providers already have plan contracts.
- **MSSP:** Health plans are required to contract with MSSP providers.
- **NF/SNF:** Providers will need a contract. Continuity of care means existing residents cannot be transferred by the plan.

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How payment processes will change for long-term supports and services (LTSS) providers will vary by the type of provider.

IHSS – in-home supports and services: Nothing changes. Beneficiaries still have the right to hire, fire and manage their providers. The county still pays.

CBAS – community-based adult services: Already in Medi-Cal managed care.

MSSP – multipurpose services and supports program: Health plans are required to contract with all MSSP programs. If you are an MSSP provider, the plan has likely already reached out to you to include you in their network.

NF/SNF – nursing facility/skilled nursing facility: Existing residents cannot be transferred by the plan unless there are serious quality issues.

Contracting With Plans

- Contact provider relations at the health plans in your area.
 - You may need to join an IPA or medical group to be in the network.
 - Phone numbers available at CalDuals.org

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To join the Cal MediConnect or MLTSS plan networks, you will need to contact provider relations at the health plans in your county. That contact information is available in the providers section of CalDuals.org.

Cal MediConnect Plan Options

Los Angeles

- Care1st, CareMore, Health Net, LA Care and Molina Health

Orange*

- CalOptima

San Diego

- Care 1st, Community Health Group, Health Net and Molina Health

San Mateo

- Health Plan of San Mateo

Alameda

- Alameda Alliance and Anthem Blue Cross

Santa Clara

- Anthem Blue Cross and Santa Clara Family Health Plan

San Bernardino

- Inland Empire Health Plan and Molina Health

Riverside

- Inland Empire Health Plan and Molina Health

*Participation in Orange County pending readiness reviews.

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The health plan options in each county are different. Beneficiaries will receive information about each plan, including their provider networks, 60 days before enrollment. The state will identify the plan that includes the providers beneficiaries currently are seeing.

Continuity of Care for Physicians

- If your beneficiary enrolls in a Cal MediConnect or Medi-Cal managed care health plan and you are not part of the network, your beneficiary has a right to see you for up to six months for Medicare services and 12 months for Medi-Cal services – if you and the plan reach agreeable terms.

- **Continuity of Care**

- Medicare services – up to 6 months
- Medi-Cal services – up to 12 months

Continuity of Care, Cont'd

- Payment terms under continuity of care will be equivalent to the Medicare and Medi-Cal fee schedule or the plan's fee schedule – whichever is higher.
- You must also show an existing relationship with the beneficiary, having seen them twice in the 12 months prior to enrollment.
- Note: This does not apply to providers of ancillary services like durable medical equipment (DME) or transportation.

Continuity of Care for LTSS Providers

- In Cal MediConnect, beneficiaries have the right to stay in their current nursing home, unless it is excluded from the plan's network for quality or other concerns. Also, they can ask their health plan about getting help to return to the community.
- In Cal MediConnect and MLTSS, beneficiaries keep their existing LTSS providers – IHSS, CBAS and MSSP.
 - Beneficiaries with IHSS providers still have the right to hire, fire and manage their providers.

Consumer Protections

The law establishing the CCI contains many protections, including:

- **Meaningful information of Beneficiary Rights and Choices**
 - Notices sent 90, 60, and 30 days prior to enrollment.
- **Self-Directed Care**
 - People will have the choice to self-direct their care, including being able to hire, fire, and manage their IHSS workers.
- **Appeal & Grievances**
 - People will receive full Medicare and Medi-Cal appeals and grievances. There will be a special Ombudsman program for Cal MediConnect.
- **Strong Oversight & Monitoring**
 - Evaluation coordinated with DHCS and CMS.
- **Continuity of Care**
 - People can continue to see their Medi-Cal providers for 12 months and their Medicare providers for six months.

Consumer Protections: Plan Readiness

- Plans have undergone thorough readiness reviews prior to beneficiary enrollment including on-site visits and desk reviews.
- California and CMS are continuing to watch very closely to ensure that the plans stay up to date with networks, systems, and resources.

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Ensuring a smooth transition during CCI implementation is critical given that the beneficiaries impacted are some of the most vulnerable.

Consumer Protections: Who To Call for Beneficiaries

- If a beneficiary has a complaint, the first point of contact is be the plan. Plans will have internal appeals and grievance procedures.
- If a beneficiary cannot resolve their complaint with the plan, there are several options:

Cal MediConnect Ombudsman Program (855) 501-3077
(Starting April 2014)

Medi-Cal Managed Care Ombudsman (888) 452-8609

Office of the Patient Advocate (866) 466-8900

How can I advise my patients?

- Your beneficiaries will receive notices 90, 60, and 30 days prior to their eligibility date. You may want to advise them to be on the lookout for these letters.
- Additional resources:
 - The Health Insurance Counseling and Advocacy Program (HICAP): 1-800-434-0222 or [INSERT County HICAP office name and number]
 - Health Care Options: (844) 580-7272 or TTY: (800) 430-7077
 - Medicare.gov > Plan Finder or 1-800-Medicare

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There are county-specific fact sheets that will be posting to Cal Duals with phone numbers for plans and HICAPs in each area.

Summary - CCI & Providers

- CCI is designed to help patients get the care and support services they need.
- Cal MediConnect can offer providers additional support and resources, including care coordination and administrative simplification.
- Strong consumer protections, including continuity of care.
- Contact plans in your county to find out how to participate.

Questions or Comments

- Visit CalDuals.org
- Email info@calduals.org
- Twitter @CalDuals
- Contact your local HICAP

